**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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| Requestor Name and Address:<br>COMBINED CHIROPRACTIC SERVICES & REHABILITATION, INC.<br>88 BRIGGS AVENUE SUITE 245<br>SAN ANTONIO TX 78224 | MFDR Tracking #: M4-11-0777-01 |
| | DWC Claim #: |
| | Injured Employee: |
| | Date of Injury: |
| Respondent Name and Box #:<br>MITSUI SUMITOMO INSURANCE USA<br>Box #: 19 | Employer Name: |
| | Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary along with the DWC060 request; however the *Table of Disputed Services* rationale for increased reimbursement states: "Medical necessity. Per Auth. Approved #711113260."

Amount in Dispute: $263.64

## PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This involves DOS 08/10/10 [sic]. Carrier paid these bills in accordance with all applicable DWC Rules and Texas Labor Code provisions."

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Medical Fee Guideline Reimbursement | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 8/4/2010 | 99212-25 | N/A | $56.91 | $0.00 |
| 8/4/2010 | 97110-GP | $167.46 | $167.48 | $167.46 |
| 8/4/2010 | 97140-GP-59 | $39.25 | $39.25 | $39.25 |
| | | | **Total Due:** | $206.71 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated 8/23/2010
   - 25, 50, T13- Separate E&M service, same physician, service not deemed "medically necessary" by payer. Med necessity denial. Appeal within 11 mos of DOS
   - 50, GP, T13-Service not deemed "medically necessary" by payer, service delivered under op PT care plan, med necessity denial. Appeal within 11 mos of DOS
   - 50, 59, GP, T13- Service not deemed "medically necessary" by payer, service delivered under op PT care plan, med necessity denial. Appeal within 11 mos of DOS

**Issues**

1. Did the requestor obtain preauthorization for the physical therapy services in accordance with 134.600?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Pursuant to rule 134.600 (p)(5)(A), states: "Non-emergency health care requiring preauthorization includes: physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   (iii) Orthotics/Prosthetics Management;
   (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;
2. The requestor submitted a preauthorization letter issued by Corvel dated 7/21/2010 which indicates that approval was granted for post op PT 3xwk x 3wks—9 visits (97110, 97140).
3. The insurance carrier denied preauthorized physical therapy services due to unnecessary medical. Sec. 413.014 (e) states: "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." The requestor seeks reimbursement for CPT code 97110 and CPT code 97140 both codes were preauthorized by the insurance carrier and therefore, the requestor is entitled to reimbursement in the amount of $206.71.
4. The requestor billed for CPT code 99212 which was not covered by the preauthorization letter dated 7/21/2010, the insurance carrier denied this charge with denial explanation of "Separate E&M service, same physician, service not deemed "medically necessary" by payer. Med necessity denial. Appeal within 11 mos of DOS." Per rule 133.305 ((b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021." The requestor did not submit documentation to support that the medical necessity issue was resolved prior to the submission of the medical fee dispute. Therefore per rule 133.307 (e) (3) (G), this CPT code is not eligible for review by the medical fee dispute resolution section and should be adjudicated under the provisions of rule 133.308. Therefore, reimbursement is not recommended for CPT code 99212.

**Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.71.

**PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $206.71 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

| Authorized Signature | Medical Fee Dispute Resolution Officer | February 11, 2011<br>Date |
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**PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**